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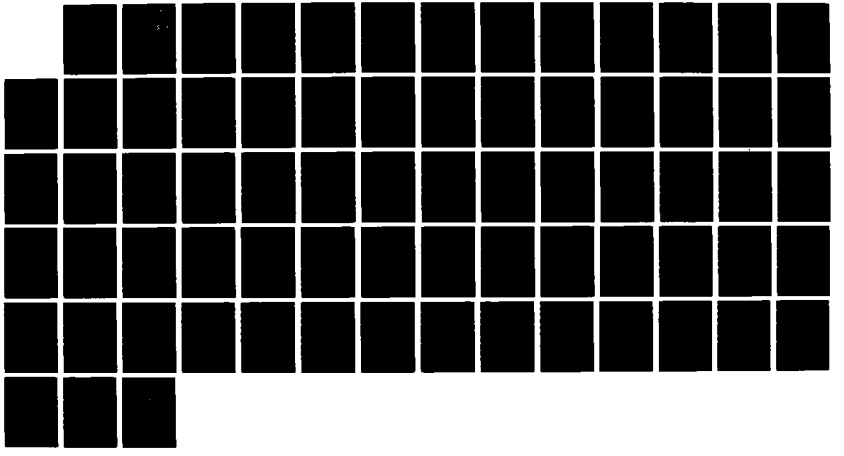

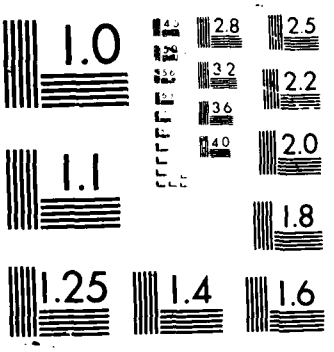
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A STUDY TO INVESTIGATE THE ADVANTAGES AND DISADVANTAGES OF A CONSOLIDATED TROOP MEDICAL CLINIC IN THE CUSTER HILL AREA OF FORT RILEY, KANSAS FROM THE VIEWPOINT OF LINE COMMANDERS AND SELECTED MEDICAL PERSONNEL

A Problem-Solving Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Hospital Administration

by

Major Randall L. Oliver, ANC

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This study analyzes the advantages and disadvantages of combining eight area Troop Medical Clinics into one consolidated Troop Medical Clinic. This study analyzes the consolidation form the viewpoints of both line commanders and selected medical personnel. The author used a questionnaire survey to research the opinions about the consolidation. He explains the implications of either decision, then makes recommendations that would lead to further acceptance of a consolidated Troop Medical Clinics.

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TABLE OF CONTENTS

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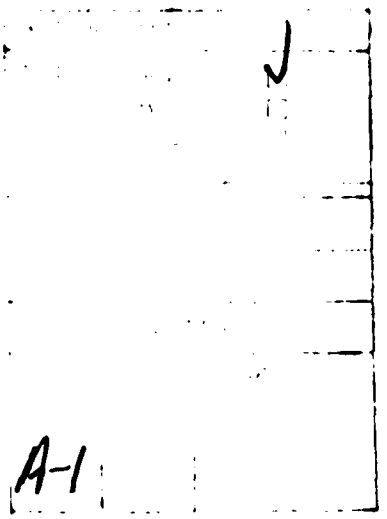

I. INTRODUCTION

General

The organization of health care facilities has traditionally been characterized by its multi-linear nature. Organizational theorists are held in awe by the ability of this type of structure to function at all. The classic dual chain of command of the health care institution is complicated further in the military setting by the influence of the line commander. The fact that the mission of the U.S. Army Medical Department is based upon support of the combat units predicates involvement of line commanders in the command and control function of U.S. Army health care facilities.

Conflict over the operational control of Troop Medical Clinics has periodically arisen wherever these facilities exist. The basis of the conflict is rooted in the conceptual differences between the line commanders and the medical unit commanders. Each group asserts that the optimal situation involves their control of health care facilities. Agreements of both a formal and an informal nature have proven to mediate the situation and provide operational stability to the TMC.

Appearance and Operation of the Present System

There are eight Troop Medical Clinics (TMC's) located on Fort Riley. The mission of the TMC's is to provide primary medical care

to the 17,284 active duty military members stationed at Fort Riley.[1] The facilities are designated as TMC's 1 through 8. The responsibilities, requirements, and relationships between FORSCOM units and Health Service Command units in Troop Medical Clinic and related medical operations are delineated in Headquarters 1st Infantry Division and Fort Riley Letter of Instruction Number 45, dated 19 June, 1979. (Appendix A)

Operational control of six of the eight TMC's is the responsibility of various commanders within the First Infantry Division, the 937th Engineer Group, and various other units assigned to Fort Riley who have medical personnel assigned to their unit. The Director of Health Services, an additional function of the Commander, USAMEDDAC, Fort Riley, has the overall responsibility to the Commanding General for the health care provided at Fort Riley, Kansas. The Division Surgeon, under the technical supervision of the Director of Health Services, supervises the operations of six Troop Medical Clinics and other health care programs. The remaining two Troop Medical Clinics are owned and operated by Irwin Army Hospital.

Staffing of the six Troop Medical Clinics over which the Director of Health Services has little actual control but bears full responsibility is provided in entirety by TOE AMEDD unit personnel and medical personnel indigenous to the line units. These personnel are counted as borrowed labor and off-set the recognized strength required for the operation of the facilities. Work performed in the Troop Medical Clinics by TOE personnel is recorded as a portion of

the MEDDAC workload. Supplies and other items necessary to provide medical care in the Troop Medical Clinics is provided by the MEDDAC.

Professional supervision is accomplished through credentialing of all medical practitioners providing care in TMC's, and through regular liaison visits by various professional and administrative personnel.

Physician and physician assistant resources for the 1st Infantry Division are attached to the Division Surgeon for assignment as necessary to meet operational requirements. Medical assets required are provided from the organic medical resources of the responsible unit for each TMC. Past performance has shown varied continuity of personnel assignment to TMC duty. Therefore, skill development and familiarity with clinical routine and quality of care is compromised to some extent.

High troop concentration on the Custer Hill area has resulted in the location of four TMC's within close proximity of one another. These clinics are open during normal duty hours, 0700 to 1630 hours, daily. Evening and night coverage is not provided in the TMC.

Each facility is capable of performing basic laboratory procedures and provides routine pharmacy service during duty hours. One TMC on the Custer Hill complex provides simple radiological services during normal duty hours. Primary care during evening and night hours is provided in the Emergency Treatment Center at Irwin Army Hospital.

In addition to the eight Troop Medical Clinics, there are 12 TOE unit aid stations functioning in order to provide initial screening and limited primary care for battalion personnel presenting for sick call. The practice is in direct contravention of the Memorandum of Understanding Among the Commanders of FORSCOM, TRADOC, and HSC, dated 5 July 1977. (Appendix B) FORSCOM condoned the continued operation of these facilities on the premise that the Troop Medical Clinics are overcrowded, rapidity of care for soldiers within the maneuver battalions, and that supervision is provided to the physician's assistant practicing in the battalion aid station setting by the appropriate brigade surgeon. (Appendix C)

The existence of battalion aid stations which provide care in garrison creates numerous problems. The physician's assistants which enable the function of the battalion aid stations are also vital to the operation of the Troop Medical Clinics. Therefore, those patients who rely upon the Troop Medical Clinic must wait until the physician's assistant completes the sick call in his battalion aid station.

Health records are maintained in battalion aid stations which have assigned a Medical Service Corps medical platoon leader. The situation arises in which there is an operational battalion aid station which is not authorized to maintain the appropriate health records. The result is a loss of encounter data and a limited available data base during the actual patient-provider encounter.

Battalion aid stations are limited to over-the-counter type drugs for garrison usage. There are wide spread instances of noncompliance

with this policy. The numbers of facilities which must be visited creates a problem in the monitorship of the battalion aid stations and the Troop Medical Clinics. Discovery of noncompliance with policy statements of standards of acceptable medical practice creates severe coordination and correction problems for the Director of Health Services. Enforcement of appropriate standards of quality without operational control requires a great deal of coordination between the Director of Health Services, his staff and the line commanders. Chains of responsibility in the present situation do not parallel the chain of command.

The large troop population of the Custer Hill area, the inadequacy of the present Troop Medical Clinic facilities, and the frequency and number of referrals to Irwin Army Hospital were perceived by the officials of Health Services Command as an indication that a treatment facility with capabilities of more definitive medical care was required. Subsequently, a proposal for construction of a consolidated Troop Medical Clinic of an approximate 10,000 square foot size was included in the fiscal year 1984 MCA Program. (Appendix D)

Conditions Which Prompted the Study

The Executive Officer, Irwin Army Hospital, suggested that some facet of the concept of a consolidated Troop Medical Clinic for the Custer Hill area of Fort Riley, Kansas would possibly provide both an interesting and useful study. Preliminary discussion of the consolidated troop dispensary topic with both line commanders and various

medical personnel revealed strong differences of opinion. Research of current literature revealed an absence of previous studies of the opinions and attitudes of line commanders versus those of medical personnel on the subject of consolidated Troop Medical Clinics.

Although a study of this nature has a limited application, knowledge of the perceptions of these two factions of the military population is necessary for determination of the most practical, efficient, effective, and harmonious means of implementing the consolidated Troop Medical Clinic.

Awareness of the opinions of the line commanders and of a group of senior medical personnel creates an awareness of areas which are potentially problematic and allows educational and marketing techniques to be employed well in advance of a major change in the methods of troop health care delivery.

Statement of the Problem

The problem was to investigate the advantages and disadvantages of a consolidated Troop Medical Clinic in the Custer Hill area from the viewpoint of both line commanders and selected medical personnel.

Objectives

The initial objective of the study was to collect data from the two groups under study and through application of various techniques, to transform the data into useful information on the opinions of each of the groups. A secondary but equally important objective was to display the results of the study in a clear and concise manner.

Criteria

A definable profile of each group under study should arise. A difference in the two groups must be illustrated, otherwise a comparison is futile.

Assumptions

Both alternatives, centralized or decentralized TMC's for the Custer Hill area, will be financially feasible at some time in the future.

Profiles of both the line commander group and the selected medical personnel group will remain somewhat constant due to the numbers of personnel in each group.

Opinion profiles of the two groups are markedly different and will be illustrated through the proposed research techniques.

Review of the Literature

Studies relating the attitudes of line commanders and medical personnel toward the Troop Medical Clinic could not be found in the literature. There are, however, articles which deal with issues as pertinent to the Troop Medical Clinic as to civilian concept of primary care. Alex McMahon wrote that hospitals have long been a source of primary care, but that these services must be offered in a more systematic fashion.[2] He also warns that the standards of primary care must be comparable to the standards of other hospital services in order for the people to accept the primary care services.[3]

A vital element of quality assurance in primary care is the careful evaluation and audit of all physician extenders. Vickery

and his numerous co-authors wrote that the acceptance of primary care which utilizes physician extenders may be compromised by even a small scale perception of incompetence.[4]

Members of society are gaining acceptance for the primary care encounter and their expectations of quality and thoroughness have greatly increased over the past decade.[5] Thorner, in his studies of the use of the military health care system by civilian beneficiaries, has observed that the use of physician extenders in the military health care system has proven offensive to many beneficiaries and has influenced many more to believe that the quality of the health care received is below that encountered in a situation in which only physicians are providers.[6]

BG Kenneth A. Cass states that the consolidated troop health clinic at Fort Bliss, Texas enjoys the total support of both the line and medical elements of that installation. He attributes the success of the clinic to the full range of services provided and, to a large degree, the perception that the clinic is a solution to the problem of obtaining quality medical care at the primary care level. (Appendix E)

Arneill mentions that economies of scale are operant in the determination of clinic size just as they influence hospital or corporation size.[7] San Agustin observed that an effective primary care operation serves to decrease the incidence of hospitalization in a cross-sectional population.[8]

In summary, a review of the literature revealed several articles which emphasize the importance of quality, accessability, and thoroughness

of primary care. The willingness of today's society to seek primary care as a preliminary to hospital care, a preventive measure to preclude the need for hospital care, or in some cases, as an alternative to inpatient care. There was no specific article which mentions specifically the Troop Medical Clinic. BG Cass' letter may be a thoroughly objective statement of the situation or may be a somewhat paternalistic viewpoint of the Commander, William Beaumont Army Medical Center.

Problem Solving Methodology

The task of collecting pertinent data for the purpose of gauging the opinions of the two groups which were subjects of the study in regard to consolidated versus decentralized Troop Medical Clinics appeared to be well suited for survey research. Determination of numbers, ratios, and proportions was necessary in order to develop characteristic profiles of each group.

The investigator employed a survey approach non-experimental research design with no direct treatment of the population. The questionnaire survey instrument was sent directly to the respondent with a cover letter which explained the purpose of the research and encouraged prompt completion and return. Instructions were provided to procedurally explain the questionnaire.

The question of sampling which is normally so crucial to the validity of a study was rendered unimportant by the relatively small size of the two populations under investigation. Questionnaires were sent to the entire population of both groups.

The Instrument

An instrument was developed to measure attitude toward centralized and decentralized Troop Medical Clinics. The instrument was pretested in order to detect question ambiguity. The instrument was a single part questionnaire made up of twenty-one opinion questions and one demographic question with four responses. (Appendix F) The statements were declarative and divided among positive and negative items. The subjects were asked to respond from Likert scale responses of strongly agree, agree, undecided, disagree, or strongly disagree. The positive and negative items were scattered in order of occurence. The responses were weighted in the following manner: positive statements - strongly agree = 5, agree = 4, undecided = 3, disagree = 2, strongly disagree = 1; negative statements - strongly agree = 1, agree = 2, undecided = 3, disagree = 4, strongly disagree = 5. Therefore, the higher the mean score, the more favorable the attitude toward centralized Troop Medical Clinics; conversely, the lower the mean score, the less favorable the attitude toward consolidated Troop Medical Clinics. The highest possible mean score was 5.0; the lowest possible mean score was 1.0. Scores were divided into three ranges; positive, undecided, and negative. A positive attitude was demonstrated by a mean score in the inclusive range of 3.2 to 5.0; an undecided attitude was a mean score in the range of 2.9 through 3.1; a negative attitude was shown by a mean score in the range of 1.0 through 2.8.

Profiling of the two groups of respondents was accomplished by tabulating the individual responses to each question, of every

survey by groups. Percentages were calculated for each response of each question by groups. The results were then analyzed to develop characteristic profiles of each group. Strong positive or negative feelings were perceived as more accurate indicators of opinions than were feelings of indecision. Therefore, the profile of each group is most accurately described by the strongly positive or negative responses.

FOOTNOTES

[1] _____. "Fourth Quarter FY 79 Statistics" Headquarters 1st Infantry Division and Fort Riley, Fort Riley, Kansas (Mimeographed)

[2] Alex McMahon, "Gearing Up for Primary Care." Hospitals 53(17): 1 September 1979. p. 105

[3] Ibid, p. 106

[4] Donald M. Vickery, M.H. Liang, Paul B. Collis, Kenneth T. Larsen, Jr., Thomas W. Morgan, Ellen D. Folland, and James V. Mummert. "Physcian Extenders In Walk-in Clinics: A Prospective Evaluation of the AMOSIST Program." Archives of Internal Medicine 135(5) May 1975 p. 722

[5] Donald I. Regenstraif. "Innovations in Hospital Based Ambulatory Care: Some Sources, Patterns, and Implications for Change." Human Organizations 36(1): Spring 1977 p. 45

[6] Robert M. Thorner. "The Use of Health Services by Civilian Beneficiaries of the Military Health Care System, A Comparative Study." Medical Care 16(4) April 1978. p. 272

[7] B.P. Arneill. "The Planning and Design Process for Ambulatory Care Facilities." Journal of Ambulatory Care Management. 1(1) January, 1978. p. 78

[8] Mario San Agustin. "Primary Care in a Tertiary Care Center: It's Impact on Hospitalization." Journal of Ambulatory Care Management. 2(1) February 1979. p. 48

II. DISCUSSION

Response to the Survey

There were thirty-five questionnaires distributed to line officers in command of battalion-size or larger units. The Chief-of-Staff, Fort Riley, at the direction of the Commanding General, arranged distribution, provided a cover letter and suspense date to aid in the response rate. (Appendix G) Even with the rather strong incentive, there were only thirty respondents for a response rate of slightly under eighty-six percent. The survey precipitated a number of telephonic responses from the group seeking further information on consolidated Troop Medical Clinics, requesting details on construction dates, location, size, and various other similar data. All questions were handled candidly.

The group of medical personnel received no distinct incentives to boost the response rate but managed to produce a very favorable response rate of seventy-six percent by returning forty-two of the fifty-four questionnaires distributed. All responses were received within seven days of the requested return deadline. The rate of response precluded the need for follow-up attempts in order to increase the response rate.

Survey Findings

The mean score of all respondents within the line commander group

was 3.2 with all respondent mean scores from the group within the range of 2.5 to 4.5. From the group of medical personnel the mean score was 3.8 with a range from 2.4 to 4.2. The data was indicative of a positive attitude toward the concept of consolidated Troop Medical Clinics on the part of both groups surveyed.

Comparison of differences between the means of the two groups through the use of inferential statistics reveals a significant difference in the opinions of the groups surveyed. (Appendix H)

Careful examination of the response patterns of line commanders and selected medical personnel yielded differences in the two groups of responses which were substantiated by comparison of the group means. There were four questions which precipitated an opposite response pattern from the two groups. On question number nine, the line commanders strongly agreed that the time expended by soldiers on medical appointments at Irwin Army Hospital has a direct relationship to the distance between the troop area and the hospital. Conversely, medical personnel expressed disagreement that the distance factor was related to the time involved in medical care.

In response to item twelve, line commanders agreed that several small Troop Medical Clinics were more able to meet the needs of the Custer Hill troop population than would a large centralized Troop Medical Clinic. Medical personnel held the opposite opinion. Responses to question number fifteen revealed the disagreement of the line commanders that consolidated facilities offered more services to customers and were more efficient than decentralized facilities while

medical personnel strongly agreed with the statement. In item number twenty, line commanders strongly agreed and medical personnel strongly disagreed with the statement that Troop Medical Clinics should be controlled by officers assigned to the division or to attached elements.

Numerous areas of agreement in opinion were also discovered. Both groups concurred, with sixty-eight percent of the line officer responses and eighty percent of the medical personnel responses agreeing that the responsibility for any activity necessitates operational control of that activity. The Troop Medical Clinic usually provides all medical services that are required in the immediate area of troop concentrations in the opinion of forty-five percent of the line commanders and forty-three percent of surveyed medical personnel. Both groups also concurred that the purpose of providing Troop Medical Clinics is to decrease the time and distance factors involved in obtaining primary medical care. The position was held by sixty-six percent of the line commanders and fifty-eight percent of the medics. Obtaining medical care in the present Troop Medical Clinic system was perceived as a problem by fifty-three percent of the line group and by fifty-six percent of the medic group.

There were sixty-three percent of the line commanders and fifty-nine percent of the medical personnel in agreement that the Troop Medical Clinic is usually able to provide the medical care required by the sick soldier. The groups agreed that the average soldier uses too much duty time for sick call with opinions of forty percent for the line and sixty percent for the medics. The statement that all

medical resources and facilities on an installation should be a direct responsibility of the Director of Health Services evoked strong agreement from thirty-six percent, and agreement from another sixteen percent of the line. The medics responded with sixty-six percent in strong agreement and another nine percent in agreement with the statement.

Summary Profiles of the Groups Surveyed

Response rates to various statements enabled the following profiles to be developed for the surveyed groups:

The line commanders agree that responsibility for any activity dictates operational control of that activity. While they strongly agree that the Director of Health Services should have direct responsibility of all medical resources and facilities, they also strongly agree that Troop Medical Clinics should be controlled by officers assigned to the division or attached units. They strongly agree that the Troop Medical Clinic is an excellent training experience, and that the primary purpose of the Troop Medical Clinic is to decrease time and distance factors in obtaining primary medical care. The line commanders agree that there is a problem in obtaining care in the present system but agree that several small Troop Medical Clinics are more able to meet the needs of the Custer Hill troop population than would a large centralized facility.

Medical personnel agree that the responsibility for any activity dictates operational control. Consensus that the Director of Health Services should have direct responsibility for all medical resources

and facilities was attested by a majority of strong agreement opinions. They agreed that obtaining primary care in the present system is a problem, and that the present Troop Medical Clinic meets the needs of the majority of the troop population served. The medical personnel strongly disagree that the caliber of care in the Troop Medical Clinic compares favorably with that of the outpatient clinics of Irwin Army Hospital. They also believe that the time and distance factors involved in caring for Custer Hill troops at Irwin Army Hospital are relatively unimportant, and strongly disagree that Troop Medical Clinics should be controlled by officers assigned to the division.

III. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The findings of this study led to the conclusion that the means of the respondents of both groups was positive. Therefore, both groups have positive opinions toward the concept of consolidated Troop Medical Clinics. Analysis of response patterns to a number of the statements revealed certain prime targets for educational marketing programs in preparation for the distant but forthcoming consolidated Troop Medical Clinic.

A potentially troublesome area is the disparity in the command and responsibility of the Troop Medical Clinics at Fort Riley. The economies of scale and the inherent efficiency and effectiveness of consolidated inprocessing centers and consolidated finance centers are obviously not readily transferable in thought process to the concept of consolidated Troop Medical Clinic operations in the Custer Hill area. The perception of medical personnel that there was a lack of quality in the level of care provided at the Troop Medical Clinic is also an area indicative of public relations focus. There was indication that neither the line commanders nor medical personnel were fully aware of the ratio of "time away from the unit" to "time devoted to transportation, waiting, and actual health care encounter".

Limitations and Implications

The survey instrument was developed explicitly for this study. Therefore, the validity was unestablished through historical reliability statistics.

Even though the majority of the populations under study were surveyed, a single survey cannot be perceived as representative of the group opinions at any other point in time.

The results of the particular study performed at Fort Riley cannot be presumed representative of any other population without risk of committing an ecological fallacy.

Indications of problem areas which developed as a result of this study may be used as guidelines for the development of implementation programs to enhance acceptance of a consolidated Troop Medical Clinic for the Custer Hill area of Fort Riley, Kansas. An awareness that numerous other problems may be discovered which grossly overshadow those discussed in this study must accompany the planning and execution of any implementation program.

Recommendations

The identification that certain potential problem areas exist is frequently a major step in the direction of either avoidance of the actual problems.

The numerous perturbations on the command, control, and even the existence of the various types of medical treatment facilities have resulted in a gross lack of clarity and uniformity. The issues

of command, control, and responsibility in regard to troop medical treatment facilities must be resolved with criteria of logic and tenability. Exposure to information from those in other areas in which consolidated Troop Medical Clinics are operational, tested, and accepted could provide reference points leading to opinion change in those who actively oppose the consolidated concept. A well planned education process could be used to inform both line commanders and medical personnel on the actual viewpoints and realities involved in the perceptions of each group. The concept that awareness facilitates acceptance has been successfully applied to numerous other Army-wide programs and certainly could be useful in facilitating the acceptance of a consolidated Troop Medical Clinic at Fort Riley, Kansas.

APPENDIX A

FORT RILEY LETTER OF INSTRUCTION NUMBER 45

AFZN-SU

LETTER OF INSTRUCTION NUMBER 45

SUBJECT: Troop Medical Clinic and Related Medical Operations

SEE DISTRIBUTION

1. PURPOSE. This letter identifies requirements, assigns responsibilities, and addresses the relationships between FORSCOM units and Health Services Command units in Troop Medical Clinic (TMC) and related medical operations at Fort Riley, Kansas.

2. GENERAL. The Director of Health Services (DHS) has the overall responsibility to the Commanding General for the health care provided at Fort Riley, Kansas. The Division Surgeon, under the technical supervision of the DHS, will supervise the operations of TMC and other health care programs. The Division Surgeon will schedule physician and physician assistant support for division medical care and field training requirements in accordance with division and installation health care requirements. Requests for physician and/or physician assistant support for unit mission and training requirements will be sent to the Division Surgeon NLT 30 days prior to the required date. Disapproval will be reserved to the Chief of Staff.

3. ASSIGNMENT OF RESPONSIBILITIES.

a. G1/DPCA

(1) Assign physicians and physician assistants to units in accordance with current TOE authorizations.

(2) Attach physician assistants to HHC, 1st Infantry Division for duty as directed by the Division Surgeon.

b. Commanders, 1st Brigade, 2d Brigade, DISCOM, DIVARTY, 1st Squadron/4th Cavalry, 1st Engineer Battalion, 937th Engineer group, 2/9 Infantry Battalion, Headquarter Commandant/Headquarters Command (units with organic medical personnel).

AFZN-SU
SUBJECT: Troop Medical Clinic and Related Medical Operations

(1) Assure Battalion Aid Stations and health care programs are operated in accordance with current Army regulations and 1st Infantry Division directives. Health records will be maintained in battalion aid stations of units authorized a medical platoon leader (1st Lieutenant, Medical Service Corps). The health records of other units will be maintained by the supporting TMC.

(2) Provide a unit orientation for assigned physicians or physician assistants.

(3) Include assigned physicians and physician assistants in unit mission and training activities as permitted by division medical care requirements.

c. Director of Health Services.

(1) Develop policy guidance for health care operations.

(2) Determine needs and provide personnel and logistical support for continued TMC operations during extended unit training, conflicting mission requirements, or upon deployment of FORSCOM units when directed by the Commanding General.

(3) Provide technical supervision of TMC and related medical operations through frequent liaison visits by physician, nursing laboratory science, radiology, patient administration, pharmacy, and medical maintenance personnel. Technical supervision is also provided through periodic health record reviews, specialty consultations, and continuing health education program's for TMC personnel.

(4) Credential all physicians and physician assistants assigned or attached to the 1st Infantry Division.

(5) Provide supplies, equipment, and medical equipment maintenance for TMC operations.

(6) Furnish the Commanding General a report on the status of installation health care delivery.

(7) Provide emergency medical services ambulance support to TMCs.

(8) Provide an ambulance (field ambulance or patient transport vehicle) for transportation of nonemergency patients and medical supplies for TMC #1.

(9) Implement and supervise the medical protion of the Personnel Reliability Program (PRP) in accordance with the Nuclear Surety Standing Operating Procedures (NUCSSOP).

AFZN-SU
SUBJECT: Troop Medical Clinic and Related Medical Operations

(10) Supervise Health Record maintenance in TMC's. In the installation setting, clinic functions requiring support such as the keeping of sterile instruments or prescription drugs, will not be provided by the BAS. Aid station personnel may perform a minor illness screening function to include distribution of over-the-counter medications in accordance with Therapeutics Agents Board guidelines.

(11) Provide sufficient personnel to staff TMCs at Camp Funston (United States Army Retraining Brigade) and United States Army Confinement Facility.

d. Commander, 16th Combat Support Hospital:

(1) Provide sufficient personnel to staff two TMCs in accordance with current applicable local, HSC, and Army Regulations and Policies. The staffing will include, as aminimum, a Chief Dispensary NCO, a medical laboratory specialist, a pharmacy specialist (ref AR 40-2), a medical records specialist, and other personnel as recommended by DA PAM 570-557. Personnel assigned to TMCs will provide routine dispensary level medical examination and treatment for assigned units and operator level maintenance for TMC medical equipment, building, and grounds.

(2) Establish and publish an efficiency rating scheme for the Chief Dispensary NCO which includes the physician in charge of that clinic. The physician in charge or assigned PA will also be included in the efficiency rating scheme for other personnel working in the TMC.

(3) Provide one 71G, Medical Records Specialist, and one 91B, Aidman, to Consolidated Processing Center for records screening and immunizations.

(4) Provide medical personnel for POM Medical Teams in accordance with the 1st Infantry Division and Fort Riley Emergency Deployment Readiness Exercise (EDRE) OPLAN.

e. Commander 1st Medical Battalion:

(1) Provide sufficient personnel to staff three TMCs in accordance with current applicable local, HSC, and Army Regulations and Policies. The staffing will include, as a minimum, a Chief Dispensary NCO, a medical laboratory specialist, a pharmacy specialist (ref AR 40-2), a medical records specialist, and other personnel as recommended by DA PAM 570-557. The staffing for TMC # 7 will additionally include one X-Ray specialist. Personnel assigned to TMCs will provide routine dispensary level medical examination and treatment for assigned units and operator level maintenance for TMC medical equipment,

buildings, and grounds.

(2) Establish and publish an efficiency rating scheme for the Chief Dispensary NCO which includes the physician in charge of that clinic.

(3) Provide TMC ambulance support for the transportation of nonemergency patients and medical supplies (TMC # 1 excluded, see paragraph 3, c, (9).

(4) Provide personnel as required by MTOE to staff the Division Surgeon's Office and necessary supplies for its operation.

f. Division Surgeon:

(1) The Division Surgeon, under the technical supervision of the DHS, will supervise the operation of TMCs and other health care programs, in accordance with division and installation health care requirements. Matters relating to the quality of medical care provided in the TMCs will be routed through the DHS to the Division Surgeon for appropriate action.

(2) Provide physicians and/or physician assistants for division medical care requirements to include TMC operations, processing of physical examinations, and augmentation of the Emergency Room at Irwin Army Hospital.

(3) Provide physicians and/or physician assistants for unit mission or training requirements based on availability of personnel and division and installation health care requirements.

(4) Publish an efficiency rating scheme for physicians and physician assistants assigned to the 1st Infantry Division. The rating scheme will include a Medical Corps Officer for each physician and physician assistant.

(5) Identify a Medical Corps Officer who will be responsible for the professional and technical supervision and development of each physician assistant. When possible that Medical Corps Officer will be the one identified in the physician assistant's efficiency rating scheme.

(6) Establish and publish standardized policies for TMC operations (including hours of operation). These should be updated at least annually.

AFZN-SU
SUBJECT: Troop Medical Clinic and Related Medical Operations

(7) Serve as a member of the MEDDAC Therapeutic Agents Board Committee, Medical Care and Evaluation Committee, and Ambulatory Patient Care Committee.

(8) Supervise the operations of the Mobile Medical Team IAW LOI Number 21, dated 13 March 1978.

(9) Supervise the activities of the Division Preventive Medical Section and the 48th Medical Detachment.

(10) Provide a medical corps officer for the Division Combined MOS Reclassification Board IAW FR Regulation 600-1.

(11) Operate a medical information system providing for the transmission of laboratory, X-Ray, specialty consultation, and other patient care related information between TMC and IAH.

(12) Supervise the medical portion of the PRP in accordance with the NUCSSOP.

(13) Supervise the medical portion of the POM in accordance with the EDRE OPLAN.

KAPLAN
MG

OFFICIAL:

SULLIVAN
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5 - MEDDAC
20 - Division Surgeon

APPENDIX B

MEMORANDUM OF UNDERSTANDING AMONG THE COMMANDER, US ARMY FORCES COMMAND; COMMANDER, US ARMY TRAINING AND DOCTRINE COMMAND; AND COMMANDER, US ARMY HEALTH SERVICES COMMAND

MEMORANDUM OF UNDERSTANDING
AMONG THE
COMMANDER, US ARMY FORCES COMMAND
COMMANDER, US ARMY TRAINING AND DOCTRINE COMMAND
AND
COMMANDER, US ARMY HEALTH SERVICES COMMAND

1. Purpose; To provide an agreed upon basis for the relationship among the Commander, US Army Forces Command (FORSCOM), Commander US Army Training and Doctrine Command (TRADOC), and the Commander, US Army Health Services Command (HSC), concerning elements of their respective commands at the installation level.

2. References.

a. AR 5-8, Host Supported Activity Relationships (Intraservice).

b. AR 5-9, Intraservice Support, Installation Area Coordination.

c. AR 10-5, Organization and Functions, DA.

d. AR 10-10, Installation Organization.

e. AR 10-41, Organization and Functions, TRADOC.

f. AR 10-42, Organization and Functions, FORSCOM.

g. AR 10-43, Organization and Functions, HSC.

h. AR 37-49, Budgeting, Funding, and Reimbursement for Base Operations Supporting Army Activities.

i. AR 40-2, Army Medical Treatment Facility, General Administration.

j. AR 40-3, Medical, Dental, and Veterinary Care.

k. AR 40-4, Army Medical Department Facilities/Activities.

l. AR 40-5, Health and Environment.

m. AR 40-61, Medical Materiel Policies and Procedures.

n. AR 50-5, Nuclear Surety.

o. AR 70-25, Use of Volunteers as Subjects of Research.

5 July 1977

p. AR 140-Series.

q. AR 200-1, Environmental Protection and Enhancement.

r. AR 210-10, Installation Administration.

s. AR 415-15, MCA Program Development.

t. AR 415-35, Minor Construction.

u. AR 602-1, Human Factors Engineering Program.

v. FORSCOM Reg 40-3, AMEDD Professional Officer Filler System.

w. FORSCOM Reg 350-2, Reserve Component Training (Draft).

3. Responsibilities. Nothing in this agreement will be construed as relieving the Commanders of FORSCOM, TRADOC, or HSC of their respective responsibilities as outline in AR 10-41, 10-42, and 10-43.

4. Objectives. The objectives of this memorandum are to:

a. Identify responsibilities and establish relationships applicable to the Commander, FORSCOM, and Commander, TRADOC, as major commanders of installations and units/activities in their respective areas of responsibility, and Commander, HSC, as a major commander of medical activities tenanted on FORSCOM and TRADOC installations, and as the single manager for the health care delivery system in his specified geographical areas of responsibility.

b. Provide policies governing respective intercommand agreements on matters of mutual interest.

c. Standardize command relationships and intraservice Support Agreements (ISSA) between host installations and HSC tenant elements.

5. General Policies.

a. Commander, FORSCOM, will command all Active Component AMEDD TOE and USAR AMEDD TOE/TDA units, and supervise the training of all ARNG AMEDD units within FORSCOM's geographical area of responsibility.

b. Commander, HSC, will command all Active Component AMEDD TDA activities within HSC's geographical area of responsibility except those field operating agencies of The Surgeon General, DA. Commander HSC, also commands

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

non-deploying RC AMEDD units following mobilization and arrival at mobilization stations.

c. A tenant unit will not be stationed on the installation of a host major command without the written concurrence of the major commands concerned.

d. The policies contained herein will govern FORSCOM/TRADOC/HSC ISSAs, which will be executed at the lowest command level practicable. Except for unusual circumstances, this memorandum will serve to standardize command and support agreements between host installation and tenant units. The installation commander will be responsible for the development and accomplishment of ISSA negotiated in accordance with policies established herein.

e. Base operations support furnished on a nonreimbursable basis need not be supported by negotiated written agreements.

f. MOUs, ISSAs, or other documents of agreement generated at the installation and addressing subjects of this MOU will be forwarded to FORSCOM and/or TRADOC for review/comment prior to implementation.

g. Installation services outlined in Section XII, Base Operations, AR 37-100-XX (except medical material/medical equipment maintenance, and procurement of medical material at MTFs), will be provided by the host installation IAW AR 210-10. Reimbursement for such support will be governed by the provisions of AR 37-49.

6. Operating Procedures.

a. Commander, Health Services Command, IAW AR 5-9, AR 10-43, AR 40-3, and AR 40-5, will provide for total health services within his geographic area of responsibility.

(1) To the maximum extent possible, subject to the priorities listed in Figure 2-1, AR 40-3, MEDDAC/MEDCEN will provide or arrange for health care services authorized by AR 40-3 and AR 40-5 to all eligible personnel on a nonreimbursable basis. These services are provided IAW existing laws and implementing regulations which state that the degree of medical care delivered to certain beneficiaries is subject to the Medical Treatment Facility (MTF) Commander's conclusive determination as to the availability of space and facilities, and the capabilities of the medical and/or dental staff; and, the provision of such services cannot interfere with the primary mission of the facility concerned. Whenever it is necessary to deny care to any category of beneficiary, the MTF Commander will inform the local installation commander and HQ, HSC.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(2) HSC is the executive agent for allocation of medical mission manpower and funds.

(3) MEDDAC/MEDCEN Commanders will advise the host installation of changing requirements to permit required support to be programmed into the budget review cycle of the host installation. Support activities will provide required budget program feeder information to the host.

(4) Installation Health Care Services provided by HSC in fixed AMEDD facilities are defined in Section II, AR 40-4. Installation and medical service does not include non-fixed medical treatment facilities identified in Section III, AR 40-4.

(5) The commander of the installation Medical Department Activity (MEDDAC) or Medical Center (MEDCEN) will have a dual role.

(a) To command assigned HSC TDA medical unit/activity, and

(b) To serve as, or designate, the installation Director of Health Services (DHS). At locations where an Army Health Clinic or Civilian Employee Health Clinic provides health services, the chief of that clinic will serve as the DHS.

(6) The Deputy for Dental Activities of the installation Medical Department Activity, or the Chief of the Department of Dentistry of the Medical Center is a dental officer with a dual role.

(a) To command the Dental Activity or direct the Department of Dentistry within the assigned HSC TDA medical establishment, with specific responsibility for the provision of oral health services to the supported patient community and the management of resources allocated to the Activity/Department.

(b) To serve as the installation Director of Dental Services (DDS). The DDS is the principal staff advisor to the installation commander and staff concerning the oral health status of military personnel and the delivery of oral health services to the supported patient community. The installation commander evaluates the performance of the DDS as prescribed in AR 623-105.

(7) The Commander, HSC has established a rating scheme for MEDDAC/MEDCEN Commanders, Directors of Health Services(DHS) and Directors of Dental Services (DDS) IAW AR 623-105.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(8) The MEDDAC/MEDCEN Commander will designate a senior MEDDAC/MEDCEN Army Nurse Corps Officer to serve as Nurse Consultant to the Chief Nurse of Active Component TOE hospitals on FORSCOM/TRADOC installations. Duties and responsibilities are identified in FORSCOM letter AFMD-PC, 7 May 1976, subject: ANC Designee for Additional Duty at Selected MEDDAC/MEDCEN, and HSC letter HSPA-M, 28 June 1976, subject: ANC Designee for Additional Duty at Selected MEDDAC/MEDCEN.

b. Active Component (AC) TOE unit resource utilization.

(1) TOE medical units have the normal STRAF, REFORGER, Special Mission Force requirement to maintain combat readiness. In addition to unit training, TOE medical units and individual personnel may assist in and provide support to the local MEDDAC/MEDCEN. The installation commander is ultimately responsible for the readiness of the units as well as the health of his command, with the attendant responsibility of determining the appropriate magnitude of the TOE Army Medical Department (AMEDD) resources which can be committed to supplemental support of the MEDDAC/MEDCEN mission; however, the following provisions apply:

(a) TOE units will not operate, or establish on an installation, any fixed medical treatment facility, e.g., dispensary, clinic, etc.

(b) TOE units may "staff" HSC fixed Medical Treatment Facilities (MTFs) when such staffing does not exceed the MTF's authorized TDA manning levels for military personnel. For manpower accounting purposes, such support will be identified adn defines as "ohters" requirements as prescribed in HSC Manpower Documents and approved by FORSCOM as well as the installation commander concerned. Identification of "others" personnel and manpower documents will be in terms of equivalent man-year commitments.

(c) "Others" personnel will not normally be rotated prior to 90 days of duty with the MTF; however, contingency requirements and local exigencies may dictate exception, particularly in a hard skill MOS.

(2) Troop Medical Clinics (TMC) are operated on an installation IAW Section II, paragraph 9a, AR 40-4.

(a) TOE "others" personnel will be technically supervised by the MEDDAC/MEDCEN Commander.

(b) AR 40-48 establishes credentialling criteria for health care extenders.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(c) Funding and equipment support requirements for all installation TMCs are the responsibility of the MEDDAC/MEDCEN.

(d) AMEDD TOE units establishing medical treatment facilities during field training exercises will utilize FORSCOM assets for professional treatment personnel. If FORSCOM installation assets are inadequate, supplemental AMEDD augmentation will be requested in accordance with FORSCOM Reg 40-3. Non-AMEDD units desiring "required but not authorized" AMEDD professional augmentation will also utilize FORSCOM Reg 40-3. FORSCOM will consolidate requirements and submit to HSC in accordance with HSC Reg 40-9.

(3) Under conditions of local civil disaster or medical emergency, installation commander(s) may task the MEDDAC/MEDCEN for professional assistance necessary to accomplish the disaster/emergency relief mission. at the earliest practicable time the installation commander will notify HQ, FORSCOM, ATTN: AFOP-CO and AFMD-OT, and Health Services Command, ATTN: HSOP-S, of actions taken.

(4) Emergency Medical Team (EMT) support to nuclear weapon accident and incident control (NAICP) and similar local contingencies will place primary reliance on the utilization of TOE resources, though MEDDAC/MEDCEN resources may be tasked with prior coordination after exhausting installation TOE resources.

(5) Non-divisional AMEDD TOE units will normally be commanded by a non-divisional AMEDD TOE Command and Control Unit or AMEDD unit with similar capability, e.g., TOE hospitals (Combat Support Hospitals, Evacuation Hospital, Field Hospitals) which are battalion-equivalent sized units. When such AMEDD command and control is not available, the installation commander may elect to subordinate the non-divisional TOE unit to a division medical battalion or another FORSCOM/TRADOC unit/activity capable of command and control AMEDD TOE units will not be attached or placed under the operational control of the MEDDAC/MEDCEN without the prior written concurrence of FORSCOM and HSC.

(6) Utilization of TOE air ambulance elements.

(a) To insure medical mission responsiveness, installation commanders having assigned air ambulance units will place such units in direct support of the MEDDAC/MEDCEN commander for medical evacuation and related medical missions.

(b) Implementation and operation of military aspects of the Military Assistance to Safety and Traffic Program (MAST) at an installation will be the responsibility of the installation commander. The DHS will technically

supervise the MAST Program at the installation level. The FORSCOM Command Surgeon monitors the program's overall staffing and operation. Technical medical surveillance of the overall MAST Program is retained in the Office of The Surgeon General, DA.

(c) Priorities for utilization of FORSCOM air ambulance resources are, in descending order:

1. Readiness.

2. Support to field exercises/installation requirements to include MEDDAC/MEDCEN support.

3. MAST.

(7) Selected TOE units may be involved in the multi-Health Service Area (HSA) optical fabrication missions. Consumable supplies, and non-TOE standard and non-standard equipment required to insure mission success, will be provided on a non-reimbursable basis by the MEDDAC/MEDCEN operating the HSA in which the Opitcal Fabrication Facility is located. Assignment of such missions will have written approval of FORSCOM, HSC, and TRADOC (for TRADOC installations). This mission will not interfere with the unit's TOE mission/readiness requirements.

(8) Manpower survey of HSC medical activities will be made by HQ, HSC. Utilization of AMEDD/non-AMEDD TOE personnel will be reflected in the section title "other" on manpower authorization documents after coordination with FORSCOM/TRADOC.

c. Reserve Component (RC) resource utilization and support.

(1) Medical augmentation to support RC Annual Training (AT) activities.

(a) For active or semi-active US Army installations having an HSC Medical Treatment Facility in year-round operation, e.g., Fort Drum and Dugway Proving Ground,

1. A medical support plan will be developed by the MEDDAC/MEDCEN which operates the fixed HSC facility. Included will be a time-phased staffing plan based on population to be supported, level of medical support to be furnished, and medical support available in the area including Active Component and Reserve Component resources.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

2. Essential minimal personnel augmentation requirements to support Reserve Component AT will be documented by the MEDDAC/MEDCEN and referred to the appropriate CONUSA after concurrence of the AT site commander. This total package will encompass positions that are feasible to be filled by RC AMEDD units/augmentees and those that must be filled by AC resources. The plan will include consideration of professional/other AMEDD officer as well as enlisted personnel requirements, ground and air abmulance support, preventive medicine, medical maintenance, etc. The CONUSA may designate one or more RC AMEDD units to support AT at an installation. Those requirements not filled by the CONUSA will be forwarded to FORSCOM/TRADOC with information copies to HSC. The requirements will be reevaluated and AC resources tasked by FORSCOM as required.

3. Funding for Active Component augmentee TDY in support of RC AT will be furnished by the supported semi-active installation, in accordance with Appendix C, FORSCOM Regulation 350-2.

4. The supporting/coordinating MEDDAC/MEDCEN will issue comprehensive mission letters to site support RC AMEDD units as soon as unit nominations are finalized by the CONUSA.

5. The entire support plan will be completed by 31 December of the calendar year (CY) previous to the scheduled AT. Continuous follow-up by the MEDDAC/MEDCEN with the RC unit(s), CONUSA, HSC, and FORSCOM/TRADOC is required.

6. The MEDDAC/MEDCEN will maintain technical supervision over the operation of the Health Clinic(s) or other fixed installation medical activities at the AT site; and will be responsible for the evaluation as appropriate of those RC AMEDD units augmenting the clinics and/or other HSC activity.

(b) State controlled (ARNG operated) sites, e.g., Camp Shelby, MS.

1. Mecical support will be planned by the State ARNG headquarters responsible for the installation's operation, or determined by the State AG. AMEDD specialty training will be coordinated with the MEDDAC/MEDCEN responsible for the AT site located in their Health Service Area.

2. Support beyond the capability of the ARNG will be referred to the appropriate CONUSA for assistance from USAR AMEDD resources or further referral to FORSCOM. Special medical technical support, such as medical maintenance, health and environment, etc., beyond the State's capabilities, will be requested from the supporting MEDDAC/MEDCEN on a reimbursable basis.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(c) Federally owned AT sites without full-time HSC treatment facility, e.g., Fort Irwin, CA.

1. These sites normally support an AT mix of ARNG and USAR but populations are generally small. The CONUSA supporting the site should assign appropriate RC AMEDD site support.

2. Problems will be referred to FORSCOM, ATTN: AFMD-OT, for resolution.

(d) RC training evaluation.

1. RC MTOE/MTDA AMEDD unit performing AT at an active HSC treatment facility will be formally evaluated by appropriate MEDDAC/MEDCEN, utilizing FORSCOM Form 1-R.

2. Units on year-round modular training will be evaluated on a single Form 1-R when all modules have completed AT. The MEDDAC/MEDCEN will evaluate (as appropriate) RC AMEDD units augmenting semi-active installations when such MTFs are operated on a year-round basis by HSC.

3. Evaluation of RCAMEDD units at all other sites, to include home station, will be provided by the supporting CONUSA IAW FORSCOM Regulation 350-2. HSC may be requested to provide evaluation when FORSCOM/TRADOC resources are depleted or HSC is better able to effect a meaningful evaluation.

(e) FORSCOM will provide HSC with an updated ITAADS magnetic tape of latest approved TDA with changes, for all USAR AMEDD TDA units/activities by end August of each year. HSC, in coordination with subordinate units, will analyze grades, position titles, MOSC/SSI, organization, mission and number of positions, and submit recommended changes with full justification to FORSCOM, ATTN: AFOP-DD, on DA Forms 2028 by 15 February the following year. Copies of printed authorization documents and/or related papers will be furnished HSC through normal distribution as actions are finalized by HQ, FORSCOM.

(f) USAR medical units designated by Reserve Component Personnel and Administrative CEnter (RCPAC) as being authorized to conduct physical examinations at home station can areceive authorizations for the required medical equipment by submitting a letter request in accordance with letter, HQ, FORSCOM, AFOP-MDC, 15 June 1976, subject: Letter of Instruction (LOI) for Processing Letter Request for Equipment Authorizations. Medical equipment obtained solely for conduct of physical examinations at home station, and which is not required by TOE units for mission accomplishment, will be

accounted for on the Technician Group TDA of the supporting Reserve Center. Upon approval and documentation the unit concerned may submit funded requisitions to the supporting MEDDAC/MEDCEN.

d. Facilities engineering support.

(1) Medical construction projects.

(a) In accordance with AR 37-49, tenant will budget, fund and reimburse the host for all minor construction (Z Account L1000) when the tenant's peculiar mission generates and, therefore, justifies the project. This policy applies only to real property facilities assigned to the tenant for its exclusive use. In coordination and with the concurrence of the Commander, MEDDAC/MEDCEN, FORSCOM/TRADOC host installation commanders will designate appropriate priorities for all minor construction peculiar to the tenant's mission, which requires completion for hospital accreditation by the Joint Commission on Accreditation of Hospitals.

(b) HSC tenant activities will obtain project approval from the host installation/MACOM for al OMA funded minor construction projects. Funded costs of such minor construction projects will not exceed $75,000. Projects with a unit cost of $5.000 or more, determined to be mission peculiar and requiring HSC funding, will be submitted through medical channels to the US Army Health Services Command, ATTN: HSCM-P, when approval has been obtained and design completed.

(c) Urgent minor construction projects IAW AR 415-35, related to construction category 500, will be forwarded from installations to HSC for medical technical review and approval. HSC will then forward the projects through FORSCOM/TRADOC for engineering technical review and forwarding to HQDA for approval.

(d) Major medical MCA projects, construction category 500, will be forwarded by MEDDAC/MEDCEN Commander with concurrence of installation commanders to Commander, HSC for validation of the project and establishment of priorities. Category 500 projects will not be included within nonmedical command priority lists or in other submissions of nonmedical projects.

(2) Maintenance and repair. The Facilities Engineer provides engineering support commensurate with available resources to accomplish medical facility maintenance and repair to insure that the MEDDAC/MEDCEN is in compliance with standards promulgated under the Occupational Safety and Health Act (OSHA); the Joint Commission on Accreditation of Hospitals (JCAH); other applicable federal, state, and local safety and health standards; and safety and health directives of HQDA. Compliance with OSHA standards by facilities which are owned by the host, but occupied by tenant HSC/MEDDAC/MEDCEN, will be the responsibility of the host on an equal priority with all other OSHA compliance actions.

(3) Environmental program. HSC environmental policies and regulations will apply concerning operation of the MEDDAC/MEDCEN. Host installation environmental policies and regulations normally associated with the command and operation of an Army installation will govern, except in operation of the MEDDAC/MEDCEN, itself, and where HSC regulations are more stringent. US Army Environmental Hygiene Agency (USAEHA) sponsored environmental field monitoring and special studies programs will be coordinated with host installation environmental coordinators. HSC/MEDDAC/MEDCEN/DHS/DDS will provide installation environmental coordinators data for input to reports required by AR 200-1. Host installation environmental office personnel will provide technical assistance to tenant HSC/MEDDAC/MEDCEN/DHS/DDS in preparation, review and coordination of environmental impact assessments and statements for which the HCS activity is the proponent.

e. Health and environmental programs.

(1) Health and environmental programs of FORSCOM/TRADOC activities and installations will be evaluated for completeness, effectiveness and appropriateness by FORSCOM/TRACOC and HSC representatives, to include mutually agreed upon support by the US Army Environmental Hygiene Agency (USAEHA). Requests for support from USAEHA at FORSCOM/TRADOC installations/activities will be originated by or coordinated with the local installation DHS 9paragraph 1-3, AR 40-5), and forwarded through HQ, FORSCOM (AFMD) or HQ, TRADOC (ATMD) to HQ, HSC (HSPA-H). The FORSCOM/TRADOC installation DHS will determine if requested services can be provided by the supporting MEDDAC/MEDCEN. Commander, USAEHA (in coordination with FORSCOM (AFMD)/TRADOC (ATMD) and HSC (HSPA-A)) will prepare an annual support plan for FORSCOM/TRADOC each fiscal year, and update it quarterly. This plan and its quarterly revisions will be furnished by HSC to FORSCOM (AFMD) and TRADOC (ATMD) for review and comment.

(2) HSC/MEDDAC/MEDCEN/DHS/DDS will provide consultation to FORSCOM/TRADOC Commanders relative to healthful working conditions for military personnel, DA civilian employees, and other eligible civilian personnel IAW Chapter 4, AR 40-5; conduct field monitoring and special studies to evaluate potential health hazards to insure that places and conditions of employment are consistent with the health standards promulgated under the provisions of Section 6, OSHA (PL 91-596), and will provide other medical requirements as set forth in Public Law 91-596. In addition, HSC/MEDDAC/MEDCEN/DHS/DDS will provide the data required for OSHA reports, regarding OSHA accidental injury, illness and loss to local safety personnel, as directed and required by HQDA. However, it is the responsibility of these medical units to evaluate all suspected and actual cases of occupational illnesses and recommend necessary corrective action. These medical units will work closely and cooperate fully with FORSCOM/TRADOC safety personnel at all levels, to ensure that the Army's Occupational Safety and Health Programs, directives, or regulations will be referred by FORSCOM (AFMD) or TRADOC (ATMD) to HSC (HSOP) for approval prior to commitment of HSC resources.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(3) To minimize potential for health hazards in materiel development, HSC and USAEHA will provide mutually agreed upon support to TRADOC Test Board activities.

f. Medical materiel.

(1) Medical materiel requirements of MEDDAC/MEDCEN located on FORSCOM/TRADOC installations will be supported by the FORSCOM/TRADOC Army Stock Fund as appropriate. Responsibility for budgeting, programming, and reporting, regarding support of HSC activities, is vested in the Chief, FORSCOM/TRADOC Division, Army Stock Fund. Responsibility for development of medical materiel data for inclusion in FORSCOM/TRADOC stock fund budgets is vested in the Commander, HSC. At installation level, this responsibility will be exercised by the MEDDAC/MEDCEN. HSC activities located on FORSCOM/TRADOC installations may prepare the medical materiel portion of the installation's stock fund program/budget based upon guidance furnished by the installation. The installation stock fund manager will forward copies of the medical portion of the installation program/budget to Commander, HSC, ATTN: HSLO-M, Ft Sam Houston, Texas 78234, at the same time that the total installation program/budget is forwarded to FORSCOM/TRADOC. HSC will review, analyze, and evaluate the medical-dental category submissions individually, from the standpoint of mission responsibilities, and provide evaluation, rationale, and recommendations to FORSCOM/TRADOC, as required or appropriate. Upon receipt of HSC stock fund program/budgets with recognition given to HSC recommendations. FORSCOM/TRADOC will provide copies of finalized programs/budgets relative to medical-dental materiel to Commander, HSC, ATTN: HSLO-M. Installation stock fund managers will provide monthly stock fund and quarterly inventory management reports, including narrative analyses, to Commander, HSC, ATTN: HSLO-M, in the same manner as prescribed for the submission of programs/budgets.

(2) Host installations will provide sufficient resources, including Ordering Officer designations and authorization for HSC personnel to place calls under blanket purchase agreements (if determined essential by the contracting officer), to assure the timely procurement of materiel and services in support of the MEDDAC/MEDCEN mission requirements.

(3) Medical materiel storage and maintenance facilities are essential components of a modern health care delivery system. FORSCOM/TRADOC will provide facilities which are proximal to the medical treatment facility and permit storage of medical materiel requiring special handling, security, and protection from the elements, and allow for the proper and safe use of materiel handling equipment.

(4) Request for major medical assemblages listed in Appendix B, AR 40-61, by Active and Reserve TOE units, will be submitted with proper justification to the supporting MEDDAC/MEDCEN. The MEDDAC/MEDCEN will forward the requisition and justification to HSC for review. HSC will forward the requisition and supporting documentation to FORSCOM/TRADOC, for approval and dispatch to the Office of The Surgeon General and US Army Medical Materiel Agency (USAMMA) for supply action.

(5) The SAILS system analyst, Director of Industrial Operations, will provide supoort to the installation medical supply activity.

g. Personnel support.

(1) AMEDD officer personnel will not be diverted or reassigned to the activity of another major command except by direction of the Surgeon General, DA. AMEDD enlisted personnel will not be reassigned to the activity of another major command except by approval of the Military Personnel Center (MILPERCEN), DA.

(2) FORSCOM/TRADOC and HSC will enter into separate master civilian personnel servicing agreements covering civilian personnel services to be provided the Commander of HSC activities which do not have operating civilian personnel offices.

(3) Army Blood Program: The Army Blood Program encompasses all aspects of the installation blood program referred to in Chapter 12, AR 40-2. Commanders are responsible as indicated below:

(a) Commander, FORSCOM/TRADOC and Commander, HSC will promote participation in and support of the Army and Military Blood Programs.

(b) Installation commander will establish an installation blood program to provide command support of the Army Blood Program. The installation blood program will be responsible for furnishing blood donors in support of the Army and/or Military Blood Programs.

(4) The Drug and Alcohol Abuse Control Program, an installation commander's responsibility, is directly supported by the MEDDAC/MEDCEN Commander IAW AR 40-5 and AR 600-85. HSC allocates sufficient resources to the MEDDAC/MEDCEN to insure missions accomplishment.

h. Military Police Support.

(1) Host installation commander is responsible for law enforcement and police investigative activities within MEDDAC/MEDCEN. Commander, MEDDAC/MEDCEN, is responsible for internal physical security and crime prevention programs.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(2) Military Police operational services provided installation wide on a common service basis, will be provided MEDDAC/MEDCEN on a nonreimbursable basis by host installation.

(3) HSC crime prevention and physical security policies and contingency plans applicable to MEDDAC/MEDCEN operations will be coordinated with host installation and take precedence over installation policies when HSC policies are more stringent.

(4) Support required to carry out above actions will be established in separate policy letters effected between applicable parties.

(5) Criminal offenses will be reported to host installation provost marshal for necessary action. Crime surveys, other than those required by the host installation, will be based on separate agreements between HSC and CID, in coordination with local provost marshal to insure an integrated crime prevention effort.

(6) Staff provost marshal functions remain responsibility of MEDDAC/ MEDCEN Commander.

i. Inspector General support.

(1) Commander, HSC, thru his Inspector General staff, will be responsible for general and special inspections of all activities under his command jurisdiction. Corrective action on HSC Inspector General findings against a FORSCOM/TRADOC installation will be coordinated by the MEDDAC/MEDCEN Commander with the installation commander. Unresolved findings will be referred to the FORSCOM/TRADOC Inspector General for resolution.

(2) Inspector General investigations and inquiries will normally be conducted by the HSC Inspector General.

(3) Inquiries into matters pertaining to HSC elements not authorized an Inspector General may be made by non-HSC Inspectors General, after mutual agreement between the HSC Inspector General and the installation Inspector General.

(4) Complaints and allegations concerning MEDDAC/MEDCEN facilities, received by the installation Inspector General, will be forwarded to the MEDDAC/ MEDCEN Commander for appropriate action. Matters pertaining to installation support, which are brought to the attention fo the MEDDAC/MEDCEN Commander, will be forwarded to the installation commander foı appropriate action.

j. Management Information System (MIS) support.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(1) FORSCOM/TRADOC host Data Processing Installations (DPI) will provide the tenant MEDDAC/MEDCEN with ADP support for all Standard Army Multi-Command Mangement Information Systems (STAMMIS), Interim DA Standard Systems. Additional ADP support for HSC-approved command-unique and AMEDD installation-unique requirements will be contigent on the availability of DPI resources and will be locally negotiated, subject to APD capability provided by HQDA, in accordance with AR 18-1.

(2) FORSCOM/TRADOC installations will provide timely ADP support to MEDDAC/MEDCEN within Systems Classification priority Classes A, B and C.

(a) Army Medical Department Property Accounting System (AMEDDPAS).

(b) Medical Stock Control (MEDSTOC), when approved as an interim DA standard system.

(c) Standard Army Intermediate Level Supply Subsystem (SAILS).

(d) FORSCOM/TRADOC managed system controls impacting on MEDDAC/MEDCEN medical stock record accounts will be coordinated with HSC.

(e) Installation managed code tables and system controls impacting on the medical stock record accounts will be coordinated with the MEDDAC/MEDCEN.

k. Judge Advocate support. The commander of the local HSC tenant activity shall have nonjudicial punishment (Article 15) authority over all enlisted members of his command. The courts-martial authority of the host installation commander shall extend to all members assigned to the tenant activity. The installation commander will provide judge advocate support to the MEDDAC/MEDCEN when the latter has no judge advocate on his staff.

l. Security and Intelligence support.

(1) MEDDAC/MEDCEN Commanders will be responsible for all aspects of the DOD Information Security Program, to include accepting, granting, denying, suspending, and revoking security clearances.

(2) Host commanders will provide administrative security services as requested by MEDDAC/MEDCEN Commanders. Such services may include but are not limited to obtaining dossiers; repairing safes/changing combinations; reproducing classified material; and, providing classified mail service, visitor control, and security education.

m. Chaplain support.

(1) HSC chaplains assigned to MEDDAC facilities on host installations will:

15 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

(a) Be under technical supervision of HSC staff chaplain.

(b) Be a member of the host installation chaplain team.

(c) Serve on the host installation chaplain duty roster.

(d) Coordinate all religious services with host installation chaplain.

(e) Attend monthly training conferences conducted by host installation chaplain.

(f) Coordinate all absences, such as leave and TDY, with host installation chaplain.

(2) FORSCOM/TRADOC host installation chaplain will:

(a) Provide after-duty hours chaplain coverage by installation duty chaplain roster for MEDDAC.

(b) Furnish denominational coverage as requested by individuals when such is not available at MEDDAC/MEDCEN.

(c) Make available chaplain coverage on an emergency basis when MEDDAC chaplain is on leave, TDY, administrative absence, etc.

n. Public Affairs support. Host installation Public Affairs Officers will:

(1) Act as release authority for public information on the installation, to include release of information authorized by AR 360-5 and AR 340-17.

(2) Coordinate with Chief, Public Affairs, HSC, through Chief, Public Affairs, FORSCOM/TRADOC on all matters not deemed appropriate for local release.

(3) Provide Command Information (CI) assistance, to include post newspaper support and CI fact sheets, to MEDDAC/MEDCEN facilities.

(4) Coordinate with MEDDAC/MEDCEN CI personnel to provide closed circuit radio/television CI programming to MEDDAC/MEDCEN facilities when and where feasible.

o. Reports: Host installation finance and accounting offices will furnish required fiscal and other reports to HSC activities or HQ, HSC. HSC activaties and the installation commander will interchange appropriate reports and information as required.

5 July 1977

MEMORANDUM OF UNDERSTANDING - FORSCOM, TRADOC, HSC

p. Problems unresolved at installation level will be referred to the next higher echelon for resolution.

7. Effective Dates and Termination.

a. This agreement becomes effective upon signature of all Parties, and supersedes Memorandum of Agreement effective 1 July 1973.

b. This Memorandum of Understanding continues effective post-mobilization.

c. This Memorandum of Understanding will be reviewed annually, during the fourth quarter of the fiscal year, or updated at any time a major policy change affects the provisions of this document.

d. This Memorandum of Understanding may be terminated upon the mutual agreement of all signatories or 90 days following the receipt of written notice of withdrawal by one of the signatories.

FREDERICK J. KROESEN General, US Army Commanding US Army Forces Command	W. E. DePUY General, US Army Commanding US Army Training and Doctrine Command	SPURGEON NEEL, M.D. Major General, mc Commanding US Army Health Services Command

APPENDIX C

LETTER ON PROVISION OF MEDICAL CARE BY TOE UNIT AID STATIONS

AFZN-SU 19 December 1978

SUBJECT: Provision of Medical Care by TOE Unit Aid Stations

Commander
United States Army Forces Command
Fort McPherson, Georgia 30330

1. This letter is in response to AFMD-PC message dated 131400 Z October 1978, subject as above.

2. The proscriptions given in paragraph 2 of the subject message mandate redesign of the existing approach to health care delivery at Fort Riley. Due to the turbulence which would be produced by this redesign, your permission to maintain certain aspects of the current system which are not permitted by this directive is requested.

3. The specific area of concern is the primary medical care provided for maneuver battalions by personnel organic to these battalions. At present, each maneuver battalions having a physician assistant (P.A.) assigned maintains a functioning battalion aid station (BAS). The BAS provides initial screening and limited primary care and has consistantly permitted the direct return to duty of 60 to 70% of battalion personnel presenting for sick call. The delay in return to duty caused by referral to the troop medical clinic (TMC) is thus avoided for a significant number of soldiers.

4. The PA. while attending sick call in the BAS, providers both primary health care for battalion soldiers and realistic training for medical platoon personnel. The need for extensive training rotations for unit medical personnel away from the battalion is reduced by this training exposure. Further, BAS personnel are given an opportunity to establish a relationship with battalion soldiers in the less complicated garrison environment that can be the basis for an effective operation in the field environment. Removal of the existing restricted but real treatment in the BAS would undoubtedly have an adverse effect on the morale of the BAS personnel.

5. The health record (HREC) is the basic means for documenting health encounters and is critical to the monitoring of health care

AFZN-SU 19 December 1978
SUBJECT: Provision of Medical Care by TOE Unit Aid Stations

delivery. Removal of the HREC from the BAS would impair assessment of the quality of health care in this area. Health care encounters with well trained, credentialed health care providers (PA's) would be inadvisable in the absence of such documentation. Certainly, careful management of HREC's is important. The existing system calls for record screening, and on referrals. The MEDDAC is actively involved in the review of HREC management and provides welcomed technical supervision. It seems that little would be gained by simply shifting the records to a location remote from this area of health care activity. The impact on the already crowded TMC's of having to manage additional HREC's would not be desirable nor would the loss of encounter data be likely to be compensated by any improvement in quality of care.

6. There is no objection to applying strict controls to the use of medications in the BAS. However, drugs presently available to the BAS are monitored and limited by the Therapeutic Agents Board, a MEDDAC committee which includes the Division surgeon. Significant examples of drugs misuse in BAS at Fort Riley have not been found.

7. The performance of any health care delivery function by medical personnel requires monitoring. The requirement certainly applies to minor illness screening as well as other aspects of primary care. At present there is no approved means for doing this without the direct involvement of trained professional personnel. The PA now provides professional supervision in the BAS with giudance by the appropriate brigade surgeon. Development of a responsible alternative method can be accomplished but will require considerable redesign of the existing mechanism.

8. It is my intent that the design for troop medical support be directed toward two goals: (1) the delivery of quality health care and (2) quality, meaningful training of health care personnel. In keeping with this approach, I would like to request your permission to continue the current level of limited, supervised health care delivery in the BAS. While I am certainly in favor of making changes which will assist in attaining these goals, I would like to avoid taking actions which will have adverse effects.

PHILLIP KAPLAN
Major General, U.S. Army
Commanding

APPENDIX D

DATA SHEET ON CONSOLIDATED TROOP MEDICAL CLINIC

DATA SHEET

FY 82-86 AND LRCP CC 500 MCA PROGRAM

DATE: 1 May 79

1. INSTALLATION: Fort Riley, Kansas

2. PROJECT TITLE: Troop Medical Clinic

3. PROJECT NUMBER: T452

4. CATEGORY CODE: 500

5. LAST YEARS TOTAL COST ESTIMATE: Not applicable.

6. THIS YEARS UPDATED COST ESTIMATE: $2,500,000

7. BLDG COST INDEX NUMBER USED: 1869

8. DESCRIPTION OF WORK TO BE DONE: Construct approximately 10,000 SF building to house consolidated Troop Medical Clinic with limited laboratory, X-ray, optometry and pharmacy capability.

9. BASIS OF REQUIREMENT: The extreme shortage of medical personnel requires maximum efficiency in their utilization. Currently there are four (4) separate Troop Medical Clinics in the Custer Hill Troop Housing Complex performing the same function. Consolidation of the manpower and resources into one location and providing adequate space for delivery of outpatient care will improve care and maximize utilization of scarce medical resources.

10. PREPARED BY:	AUTOVON:
2LT Vicki Lewis	856-7207
MAJ James L. Newborn	856-2364

C3

APPENDIX E

LETTER FROM BG KENNETH A. CASS

ATZC-DMZA 29 January 1980

COL Frank F. Ledford, Jr., M.D.
CDR, MEDDAC, Irwin Army Hospital
Fort Riley, KS 66442

Dear Frank:

The Consolidated Troop Health Clinic at Fort Bliss was opened in November 1975 and was the result of a consolidation of five clinics, serving roughly 23,000 troops on post. The concept has worked very well at this installation. The clinic is physically located in an area which is central to the majority of billets on post and is, thus, within walking distance for most of the troops that reside in the barracks. It is some distance from the Basic Training area and the troops are brought from that area to the clinic by bus the first thing in the morning.

We use a staggered sick call system so that each major unit is assigned a "sick call." The clinic begins operation at 0630 in the morning, which is the time alloted for the basic training unit. Other units are then appointed at approximately 2-hour intervals. Emergencies, of course, are seen at any time. Only active duty personnel are seen in this facility, and we average around 200 visits a day.

An individual presenting for sick call is first seen by a 91C as a screener and if his medical requirements are above that skill level, he is seen by a Physician's Assistant or a physician. We have four physicians assigned to the Clinic, including the Flight Surgeon. The regimental surgeon of the Armored Cavalry Division also works in the clinic. There are five Physician's Assistants assigned to the Medical Center and three Physician's Assistants from the 3d ACR also work in the clinic as their duties permit.

We have a superb physical facility which was specifically

designed for the delivery of ambulatory care. The full time staff at the clinic provides for good continuity of operation in contrast to that achieved by a detailed staff, and encourages loyalty to and pride in the operation of the facility by the staff.

The Consolidated Troop Health Clinic provides full scale, one-stop medical service to the active duty soldier. We have full X-Ray, Laboratory and Pharmacy facilities as well as Physical Therapy capability. A Dermatologist spends two half-days in the clinic per week and a Physical Therapist trained as an orthopaedic screener sees all orthopaedic patients prior to referral to the hospital.

All medical activities are accomplished in this facility. We have no aid stations at the unit level except at McGregor Range which is 30 miles to the north. Everything, including immunizations, is accomplished at the clinic. We believe this provides good control to deliver the best medical care as well as to accomplish the maintenance of medical records.

There was initially some resistance to the concept of a consolidated clinic by the commanders at Fort Bliss. The personnel at the clinic have strived to provide good service to the soldier, and the officers and NCO's at the clinic have made a concerted effort to establish effective liaison with the commanders and first sergeants of the units to assure that the perception of the line is that the clinic is there to be the solution rather than part of the problem. As a result, the concept is now enthusiastically endorsed by the line. The consolidaton has provided us the ability to have effective control of the quality of medicine delivered to the patients as well as to provide programs of continuing education for the medical personnel at the clinic. A good rapport has been established with the staff at the hospital so that the Concolidated Clinic is generally viewed as an integral part of the medical center, and I think there is a minimum of the "we-they" feeling. The specialist staff at the hospital has been most cooperative in assisting with continuing education of the clinic personnel.

In summary, the Troop Health Clinic is very well accepted and its virtues extolled by the individual's commanders as well as the Commanding General of Fort Bliss. It is an

COL Frank F. Ledford, Jr., M.D. 29 January 1980

idea that should have been implemented throughout the Army years ago, and I wish you success in bringing Fort Riley into the modern medical world.

Sincerely,

KENNETH A. CASS, M.D.
Brigadier General, MC
Commanding

APPENDIX F

SAMPLE QUESTIONNAIRE

SURVEY

INSTRUCTIONS:

Circle the one response for each question which best describes your personal opinion.

1. Responsibility for any activity dictates operational control of that activity.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly Disagree

2. The unit Troop Medical Clinic environment is an excellent training experience for medical personnel assigned to combat units.

a. Strongly disagree
b. Mildly disagree
c. Undecided
d. Mildly agree
e. Strongly agree

3. The unit Troop Medical Clinic provides all medical services that are required in the immediate area of troop concentrations.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

4. The primary purpose of providing Troop Medical Clinics is to decrease the time and distance factors of obtaining primary medical care.

a. Strongly disagree
b. Mildly disagree
c. Undecided
d. Mildly agree
e. Strongly agree

5. Obtaining medical care in the present Troop Medical Clinic system is a problem.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

SURVEY (Continued)

6. The Troop Medical Clinic is frequently unable to provide required medical care for the sick soldier.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

7. A large percentage of the soldiers seen in the Troop Medical Clinic are referred to the hospital for additional medical care.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

8. Time expended by soldiers on sick-call is directly related to the distance between their unit and the Troop Medical Clinic.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

9. Time expended by soldiers on medical appointments at Irwin Army Hospital is directly related to the distance between the troop area and the hospital.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

10. Troop Medical Clinics should be open twenty-four hours a day to provide primary medical care for active duty personnel.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

11. The duty time expended by soldiers on sick-call in the troop medical clinic is much greater at Fort Riley than at other posts where I have been assigned.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

SURVEY (Continued)

12. Several small TMC's are more able to meet the primary medical care needs of the Custer Hill troop population than would a large centralized TMC.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

13. Distance between the Custer Hill area and Irwin Army Hospital is a major problem for the soldier who needs medical care.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

14. Medical and surgical specialty physician services should be available at the Troop Medical Clinic.

a. Strongly Agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

15. Consolidated facilities offer more services to customers and are more efficient than decentralized facilities.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

16. The duty time used by the average soldier for sick call is excessive.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

17. The average time away from duty for the soldier who reports for sick call is longer than necessary.

a. Strongly agree
b. Agree
c. Undecided
d. Disagree
e. Strongly disagree

SURVEY (Continued)

18. A majority of personnel who report for sick-call require only those medical services which are currently available at the Troop Medical Clinic.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

19. The quality of medical care in the Troop Medical Clinics compares favorably with the quality available in the outpatient clinics of the hospital.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

20. Troop Medical Clinics should be controlled by officers assigned to the division or attached units.

a. Strongly disagree
b. Disagree
c. Undecided
d. Agree
e. Strongly agree

21. All medical resources and facilities on an installation should be a direct responsibility of the Director of Health Services (Hospital Commander).

a. Strongly Agree
b. Agree
c. Undecided
d. Agree
e. Strongly agree

22. Demographic data.

a. Age_____
b. Rank_____
c. Branch_____
d. Time at Ft. Riley

APPENDIX G

COVER LETTERS

S: 17 January 1980

AFZN-CS 2 January 1979

SUBJECT: TMC Questionnaire

SEE DISTRIBUTION

1. A study to determine the feasibility of a consolidated Troop Medical Clinic on Custer Hill is being conducted.

2. Request each addressee complete the attached questionnaire and return to Major R.L. Oliver, Headquarters, MEDDAC, Irwin Army Hospital.

3. Questionnaire should be in Major Oliver's possession NLT COB 17 January.

FOR THE COMMANDER:

1 Incl
TMC Questionnaire

EDWARD W. NEWELL
Colonel, GS
Chief of Staff

DISTRIBUTION:

Cdr, 1st Brigade	1-28 Inf	1-7 FA	541st Maint
Cdr, 2d Brigade	2-16 Inf	3-6 FA	1-4 Cav
Cdr, DIVARTY	1-34 AR	1st Med	1st Engr Bn
Cdr, DISCOM	1-63 AR	1st S&T	1st Avn Bn
Cdr, 937th Engr Gp	2-63 AR	701st Maint	1st MI
Cdr, 1-2 Inf	4-63 AR	16th CSH	121st Sig
Cdr, 1-18 Inf	1-5 FA	34 Engr	2-51st ADA
			716th MP

CF:
Cdr, IAH
Div Surg
G1
G2
G3
G4

DEPARTMENT OF THE ARMY
FORT RILEY MEDDAC/IRWIN ARMY HOSPITAL
FORT RILEY, KANSAS 66442

AFZN-DM-X

4 January 1980

SUBJECT: Opinion Survey

TO: Selected AMEDD Personnel

1. In order to acquire opinions of key medical personnel in regard to operations and services of Troop Medical Clinics the attached questionnaire has been developed.

2. Your prompt completion and return of the survey instrument will greatly assist the researcher in the collation of responses and finalization of this study.

3. Please select the single response that you feel most appropriately answers the question.

4. Please do not sign the questionnaire. All individual responses are to be anonymous and will be held in strict confidence.

5. Any questions in regard to this survey and requests for copies of the results should be addressed to MAJ Randall L. Oliver, Administrative Resident, Irwin Army Hospital, Fort Riley, KS 66442. Duty telephone: 913-239-7146.

6. Please complete the questionnaire promptly and return it in the enclosed envelope. Thank you for your cooperation.

Randall L. Oliver

RANDALL L. OLIVER
MAJ ANC
Administrative Resident

APPENDIX H

COMPUTATION OF DIFFERENCES IN MEANS

APPENDIX H

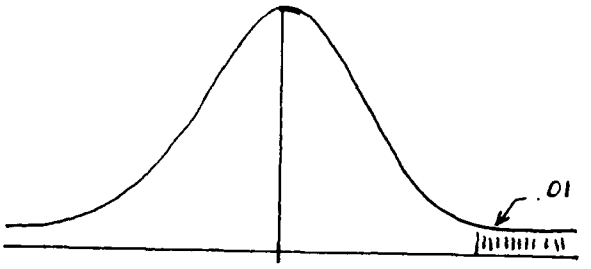
Comparison of the Means

Sample Data

Line Officers	Medical Personnel
n_1 = 30 respondents	n_2 = 42 respondents
$\bar{x}_1$ = 3.2 mean score	$\bar{x}_2$ = 3.8 mean score
s_1 = .33 points	s_2 = .3 points

$H_o : \bar{x}_1 - \bar{x}_2 \leq 0$

$H_a : \bar{x}_1 - \bar{x}_2 > 0$



One-tailed test at alpha = .01

Since n_1 and n_2 are both greater than 30, the sampling distribution of $\bar{x}_1 - \bar{x}_2$ follows a normal distribution.

$$s_{\bar{x}_1 - \bar{x}_2} = \sqrt{\frac{s_1^2}{n_1} + \frac{s_2^2}{n_2}} = \sqrt{\frac{(.33)^2}{30} + \frac{(.3)^2}{42}} = \sqrt{.0036 + .0021}$$

$$= \sqrt{.0057}$$

$$= \sqrt{.0754}$$

Critical Z value = +2.33

$$Z_{\bar{x}_1 - \bar{x}_2} = \frac{(\bar{x}_1 - \bar{x}_2) - (\mu_1 - \mu_2)}{.0754} = \frac{(3.2 - 3.8) - 0}{.0754} = \frac{.6}{.0754} = 7.96$$

Therefore: reject H_o, there is not a significant difference in the means of the two populations.

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END

JAN.

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